

**TENNESSEE GENERAL ASSEMBLY  
FISCAL REVIEW COMMITTEE**



**FISCAL NOTE**

**SB 1286 - HB 1966**

March 26, 2009

**SUMMARY OF BILL:** Effective January 1, 2010, requires health insurance companies to establish internal and external grievance and appeals processes that are consistent with the processes required by the federal Employee Retirement Income Security Act (ERISA). Requires TennCare-contracted HMOs to establish internal and external grievance and appeals processes to permit review of coverage and payment determinations. These processes must be consistent with the processes required by ERISA or the Centers for Medicaid and Medicare Services (CMS). Removes HMOs from the additional liability for bad-faith failure to pay promptly provisions and requires their adherence to the prompt pay standards established for all health insurance entities.

**ESTIMATED FISCAL IMPACT:**

**State Expenditures – Net Impact - Not Significant**

Assumptions:

- According to the Department of Commerce and Insurance, the processes developed by the insurance companies will be reviewed to determine if they comply with the requirements of this bill. The Department will no longer be responsible for the review of decisions of independent reviewers as this will be covered in the health insurance and HMO plans for grievances and appeals.
- Currently there is an independent review process provided by the Department for provider payment determinations. ERISA does not address provider payment disputes, therefore the Department will continue to provide this service.

**CERTIFICATION:**

This is to duly certify that the information contained herein is true and correct to the best of my knowledge.

A handwritten signature in cursive script, reading "James W. White".

James W. White, Executive Director

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